MITCHELL ENDOSCOPY CENTER

7605 Forest Avenue, Suite 211
Richmond, VA 23229
(804) 282-3114

PATIENT REGISTRATION FORM

PATIENT INFORMATION

TITLE	FIRST NAME	M.I.	LAST NAME		
ADDRESS		CITY		STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE		SSN#	
BIRTHDATE	CIRCLE ONE MALE / FEMALE	MARITAL STATUS	SPOUSE'S NAME		
EMPLOYER		OCCUPATION			
WORK ADDRESS		CITY		STATE	ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		TELEPHONE NUMBER	
CLAIMS MAILING ADDRESS	CITY	STATE	ZIP
ID# / GROUP #		SUBSCRIBER'S NAME	DATE OF BIRTH
SECONDARY INSURANCE COMPANY		TELEPHONE NUMBER	
CLAIMS MAILING ADDRESS	CITY	STATE	ZIP
ID# / GROUP #		SUBSCRIBER'S NAME	DATE OF BIRTH

I authorize Mitchell Endoscopy Center to release information required by my insurance company. I authorize payment of benefits directly to Mitchell Endoscopy Center. I understand that I am financially responsible to Mitchell Endoscopy Center for charges not covered by this assignment and in the event of default, I agree to pay all costs of collections including reasonable attorney fees. This authorization and assigment will remain in effect until a notification of change is received by Mitchell Endoscopy Center.

Signature: _____ **Date:** _____

MEDICARE LONG-TERM AGREEMENT

I authorize Mitchell Endoscopy Center to release any information needed for Medicare claims to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers.

Signature: _____ **Date:** _____

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MEDICAL HISTORY

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Referring Physician: _____

Why are you here? _____

_____

Medical Problems/History (ex: asthma, diabetes, depression, etc.): _____

_____

_____

Surgical History: _____

_____

_____

Date of Last Colonoscopy: _____ **Location/Physician:** _____

Family History:	Circle One		Relationship	Age Diagnosed
Colon Cancer	YES	NO	_____	_____
Colon Polyps	YES	NO	_____	_____
Esophageal Cancer	YES	NO	_____	_____
Stomach Ulcer/Cancer	YES	NO	_____	_____
Colitis / Crohn's	YES	NO	_____	_____
Diabetes	YES	NO	_____	_____
High Blood Pressure	YES	NO	_____	_____
Celiac Disease	YES	NO	_____	_____
Do You Smoke ?		NO	YES - HOW MUCH_____	Counseling Done _____
Do You Drink Alcohol ?		NO	YES - HOW MUCH _____	Counseling Done _____

_____ _____

Physician's Signature Date Reviewed

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

A copy of Mitchell Endoscopy Center **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state laws, has been made available to me. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations permitting to medical assigment of benefits apply.

Signed: _____ **Date: _____**

If not signed by patient, please indicate relationship to patient (e.g. spouse, mother, father, etc.)

Relationship: _____ **Witnessed by: _____**

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time): _____

By (name and title): _____

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DISCLOSURES TO FAMILY MEMBERS AND FRIENDS

I, _____, understand that disclosures may be made to my family and friends related to my health or as needed for payment for health care services. I understand that my doctor will only disclose information relevant to current treatment. I agree that my doctor may disclose health care information to:

(complete all that apply)

Name	Relationship	In Person	By Phone

I authorize Mitchell Endoscopy Center to leave messages, test results and/or appointment information on my answering machine or voice mail.

Phone Number(s) _____

Patient Signature _____ Date _____

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MEDICATION LIST

Date _____

Name _____ DOB _____

Local Pharmacy _____ PH# _____

Mail Order Pharmacy _____ PH# _____

DRUG NAME	DOSAGE	FREQUENCY

Vaccinations: ☐ FLU – DATE _____ ☐ PNEUMONIA – DATE _____

_____ _____

Physician's Signature Date